

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044906
STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 401

FILED DEC 2 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Pettis</u> | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia</u> | | c. CITY OR TOWN <u>Sedalia</u> | |
| Length of stay in 1b <u>27 yrs.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1931 E. 7th</u> | | d. STREET ADDRESS (If outside, give location) <u>1931 E. 7th</u> | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan Vollmer Meinberg</u> | | | 4. DATE OF DEATH Month Day Year <u>Nov. 26, 1963</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-18-1877</u> |
| 9. AGE (last birthday) <u>89</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) <u>Mascoutah, Ill</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | |
| 13a. FATHER'S NAME <u>Vollmer</u> | | 13b. MOTHER'S MAIDEN NAME _____ | 14. NAME OF HUSBAND OR WIFE <u>Samuel Meinberg</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | 17. INFORMANT Address <u>Mrs Frances Mehl - Sedalia</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure with pulmonary edema</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| DUE TO (b) <u>Arteriosclerotic Heart disease</u> | | | <u>10 year</u> |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Healing fracture of hip - operated twice past year</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from <u>Feb. 3, 1960</u> to <u>Nov. 26, 1963</u> and last saw him alive on <u>Nov. 25, 1963</u> Death occurred at <u>10:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Albert J. Campbell MD</u> | | 22b. ADDRESS <u>312 1/2 So. Ohio, Sedalia, Mo.</u> | 22c. DATE SIGNED <u>11-27-63</u> |
| 23a. BURIAL, CREMATION, REQUIEM (Specify) <u>Burial</u> | 23b. DATE <u>Nov. 29, 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u> | 23d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>M. Laughlin Bros - Sedalia</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 29, '63</u> | 26. REGISTRAR'S SIGNATURE <u>Frances Mehl</u> |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed K.P.M. Liary

Licensed Embalmer No. 2153

P. O. Address Sedalia, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.